

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 185

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits write RURAL OR and give nearest town) <u>Harford</u>				CITY (If outside corporate limits write RURAL and give nearest town) <u>Harford</u> 24			
TOWN <u>Harford</u> 18 yrs.				STREET ADDRESS (If rural, give location) <u>560 Alliance St.</u> 1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED:		(First) <u>Marice</u> (Middle) <u>Noble</u> (Last) <u>Boddy</u>		4. DATE OF DEATH		(Month) <u>April</u> (Day) <u>11</u> (Year) <u>1955</u>	
(Type or Print)							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 2-1893</u>	9. AGE last birthday: <u>61</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Proving Ground</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jim Boddy</u>				14. MOTHER'S MAIDEN NAME: <u>Louise Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Mr. Rula Boddy (Wife) 560 Alliance St. Harford, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
443X Immediate cause (a) <u>Hypertensive CV disease</u> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lerald C Palmer</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/11/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>4/14/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Mt Zion</u>		LOCATION (City, town, or county) (State): <u>Earl Co. Md.</u>	
DATE REC'D BY LOCAL REG: <u>Apr. 12-1955</u>		REGISTRAR'S SIGNATURE: <u>A. L. Lewis m. d.</u>		24. FUNERAL DIRECTOR: <u>Funerary Co. & Son</u>		ADDRESS: <u>Harford, Md.</u>	

RECEIVED

APR 14 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 18&21 Film G180 4-15-55 am

3707

CERTIFICATE OF DEATH

Reg. Dist. No. 185

03694

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>HAVER DE GRACE</u>		LENGTH OF STAY (in this place) <u>2 DAYS</u>		CITY OR TOWN <u>HAVER DE GRACE</u>		24	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>				STREET ADDRESS <u>Past Rd.</u>		1	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>CLARENCE</u> (Middle) <u>Bond</u> (Last)				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>2/20/1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Classified Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE Bond</u>				14. MOTHER'S MAIDEN NAME <u>MELINDA MOORE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If Yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>General Delivery Mrs. Beulah J. Bond - Aberdeen, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
916.0 IMMEDIATE CAUSE (A) <u>Shock - 50% 2° & 3° Burns</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Esophagitis + gastritis, new and old</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cirrhosis of liver, Dilated t.b.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>Havre de Grace</u> (County) <u>Harford</u> (State) <u>Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>3-30-55</u> <u>700</u> P. M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>Kerosene stove exploded</u>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., M, from the causes and on the date stated above.							
SIGNATURE <u>Wm. K. Beaudre</u>				DATE SIGNED <u>4-2-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		LOCATION (City, town, or county) <u>Mt. Aberdeen Md.</u> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Atelia J. Bullock-Thorne, Inc.</u>		ADDRESS	
DATE <u>Apr. 2-1955</u>							

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3708

03695

CERTIFICATE OF DEATH

Reg. Dist. No. 195-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Harford</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Harre de Grace</i>		<i>about 25 yrs.</i>		TOWN <i>Harre de Grace</i>		<i>24</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>825 Juniata St.</i>				STREET ADDRESS (If rural give location) <i>825 Juniata St.</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Joseph</i> (Middle) <i>Morgan</i> (Last) <i>Brown</i>				(Month) <i>4</i> (Day) <i>23</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>Negro</i>	<i>Single</i>	<i>6-21-1870</i>	<i>84</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Janitor</i>		<i>Factory</i>		<i>Perryman, Md.</i>		<i>U. S. A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Ephraim Brown</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Mrs. Ellen Cooper - Abingdon, Md.</i>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>420.0 Congestive Heart Failure</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arteriosclerotic Heart disease</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hepatic Insufficiency</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2/5</i> , 19 <i>55</i> , to <i>4/23</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/23</i> , 19 <i>55</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>George J. Stansbury</i>				ADDRESS (Street, city, town, state) <i>569 Revolution St., Harre de Grace, Md.</i>			
DATE <i>4/24/55</i>				DATE SIGNED <i>4/24/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>4-26-55</i>		<i>4-26-55</i>		<i>Union Methodist</i>		<i>W. A. Berdeen, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Apr 25 1955 - A. L. Lewis</i>		<i>M. A. Bullock</i>		<i>Harre de Grace, Md.</i>			

CERTIFICATE OF DEATH

REG-1000-100

1. USUAL RESIDENCE WHERE DECEASED

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. RACE

12. BIRTH DATE

13. BIRTH PLACE

14. EDUCATION

15. RELIGION

16. SOCIAL SECURITY NUMBER

17. PREVIOUS ILLNESS

18. PRESENT ILLNESS

19. MEDICAL HISTORY

20. PHYSICIAN'S SIGNATURE

21. MEDICAL EXAMINER'S SIGNATURE

22. CORONER'S SIGNATURE

23. DEATH CERTIFICATE NUMBER

24. COUNTY

25. CITY

26. STATE

27. ZIP CODE

28. TELEPHONE

29. HUSBAND'S NAME

30. WIFE'S NAME

31. CHILDREN'S NAMES

32. OTHER RELATIVES

33. DECEASED'S SIGNATURE

34. WITNESSES' SIGNATURES

35. DECEASED'S ADDRESS

36. DECEASED'S PHONE

37. DECEASED'S OCCUPATION

38. DECEASED'S EDUCATION

39. DECEASED'S RELIGION

40. DECEASED'S SOCIAL SECURITY NUMBER

41. DECEASED'S PREVIOUS ILLNESS

42. DECEASED'S PRESENT ILLNESS

43. DECEASED'S MEDICAL HISTORY

44. DECEASED'S PHYSICIAN'S SIGNATURE

45. DECEASED'S MEDICAL EXAMINER'S SIGNATURE

46. DECEASED'S CORONER'S SIGNATURE

47. DECEASED'S DEATH CERTIFICATE NUMBER

48. DECEASED'S COUNTY

49. DECEASED'S CITY

50. DECEASED'S STATE

51. DECEASED'S ZIP CODE

52. DECEASED'S TELEPHONE

53. DECEASED'S HUSBAND'S NAME

54. DECEASED'S WIFE'S NAME

55. DECEASED'S CHILDREN'S NAMES

56. DECEASED'S OTHER RELATIVES

57. DECEASED'S SIGNATURE

58. DECEASED'S WITNESSES' SIGNATURES

59. DECEASED'S ADDRESS

60. DECEASED'S PHONE

61. DECEASED'S OCCUPATION

62. DECEASED'S EDUCATION

63. DECEASED'S RELIGION

64. DECEASED'S SOCIAL SECURITY NUMBER

65. DECEASED'S PREVIOUS ILLNESS

66. DECEASED'S PRESENT ILLNESS

67. DECEASED'S MEDICAL HISTORY

68. DECEASED'S PHYSICIAN'S SIGNATURE

69. DECEASED'S MEDICAL EXAMINER'S SIGNATURE

70. DECEASED'S CORONER'S SIGNATURE

71. DECEASED'S DEATH CERTIFICATE NUMBER

72. DECEASED'S COUNTY

73. DECEASED'S CITY

74. DECEASED'S STATE

75. DECEASED'S ZIP CODE

76. DECEASED'S TELEPHONE

77. DECEASED'S HUSBAND'S NAME

78. DECEASED'S WIFE'S NAME

79. DECEASED'S CHILDREN'S NAMES

80. DECEASED'S OTHER RELATIVES

81. DECEASED'S SIGNATURE

82. DECEASED'S WITNESSES' SIGNATURES

83. DECEASED'S ADDRESS

84. DECEASED'S PHONE

85. DECEASED'S OCCUPATION

86. DECEASED'S EDUCATION

87. DECEASED'S RELIGION

88. DECEASED'S SOCIAL SECURITY NUMBER

89. DECEASED'S PREVIOUS ILLNESS

90. DECEASED'S PRESENT ILLNESS

91. DECEASED'S MEDICAL HISTORY

92. DECEASED'S PHYSICIAN'S SIGNATURE

93. DECEASED'S MEDICAL EXAMINER'S SIGNATURE

94. DECEASED'S CORONER'S SIGNATURE

95. DECEASED'S DEATH CERTIFICATE NUMBER

96. DECEASED'S COUNTY

97. DECEASED'S CITY

98. DECEASED'S STATE

99. DECEASED'S ZIP CODE

100. DECEASED'S TELEPHONE

101. DECEASED'S HUSBAND'S NAME

102. DECEASED'S WIFE'S NAME

103. DECEASED'S CHILDREN'S NAMES

104. DECEASED'S OTHER RELATIVES

105. DECEASED'S SIGNATURE

106. DECEASED'S WITNESSES' SIGNATURES

107. DECEASED'S ADDRESS

108. DECEASED'S PHONE

109. DECEASED'S OCCUPATION

110. DECEASED'S EDUCATION

111. DECEASED'S RELIGION

112. DECEASED'S SOCIAL SECURITY NUMBER

113. DECEASED'S PREVIOUS ILLNESS

114. DECEASED'S PRESENT ILLNESS

115. DECEASED'S MEDICAL HISTORY

116. DECEASED'S PHYSICIAN'S SIGNATURE

117. DECEASED'S MEDICAL EXAMINER'S SIGNATURE

118. DECEASED'S CORONER'S SIGNATURE

119. DECEASED'S DEATH CERTIFICATE NUMBER

120. DECEASED'S COUNTY

121. DECEASED'S CITY

122. DECEASED'S STATE

123. DECEASED'S ZIP CODE

124. DECEASED'S TELEPHONE

BUREAU V. S.

APR 26 1955

RECEIVED

3722

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Darlington</u>		LENGTH OF STAY (in this place) <u>one yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Darlington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARGARET JANE BURKINS</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>April 12 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>July 13, 1875</u>	
9. AGE last birthday: <u>79</u> yrs.		10. MONTHS <u>12</u>		11. DAYS <u>12</u>		12. HOURS <u>19</u> MIN.	
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired <u>Retired Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Rising Sun, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>William Penn Shade</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ann Southerland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>ms. Harmon Alexander</u>			
17. INFORMANT & ADDRESS: <u>Rising Sun, Md.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
483X Immediate cause (a) <u>Acute Heart Attack</u>							
Antecedent cause(s) (b) <u>Grapple</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Grapple</u>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/12/55</u> , to <u>4/12/55</u> , that I last saw the deceased alive on <u>4/12</u> , 19 <u>55</u> , and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>F. P. [illegible]</u> (Degree or title)				ADDRESS <u>Darlington Md.</u> DATE SIGNED <u>4/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE HEREOF <u>April 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Brookview</u>		LOCATION City, town, or county (State) <u>Rising Sun Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 12/1955</u>		REGISTRAR'S SIGNATURE <u>C. H. Kirk</u>		24. FUNERAL DIRECTOR <u>J. E. Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	
(Cecil Co. - no pink slip)							

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 21 1953

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03697

3723

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Aberdeen Proving Gd.</u>		<u>7 days</u>		TOWN <u>Edgewood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2151-1 U.S. Army Hosp</u>				STREET ADDRESS (If rural give location) <u>4 Love Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Stanley George Burr</u>				<u>April 8 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1918</u>	9. AGE last birthday <u>36</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTH PLACE (State or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Bonto Burr</u>				14. MOTHER'S MAIDEN NAME <u>Helen Sara Kline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes WWII, Korea</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Mable Virginia Burr</u> ^{wife}	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Gastro Intestinal hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ventricular Tachycardia heart failure</u>				<u>with congestive</u> <u>1 week</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Old myocardial infarction with arterio-</u>				<u>-3 yrs</u>			
				<u>sclerotic heart disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>NA</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>NA</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>NA</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>NA</u>			
22. I hereby certify that I attended the deceased from <u>1 April, 1955</u> , to <u>8 April, 1955</u> , that I last saw the deceased alive on <u>8 April, 1955</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Peter P. Mayock Jr.</u>		ADDRESS (Street, city, town, state) <u>2151-1 USAH, APG, Md.</u>		DATE SIGNED <u>April 8, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cullington Md.</u>		LOCATION (City, town, or county) (State) <u>Ft. Myer Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Smith</u>		ADDRESS <u>Harford Md.</u>	
DATE <u>Apr. 12 - 1955</u>							

BUREAU V. S.

RECEIVED
APR 13 1961

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03698

3709

CERTIFICATE OF DEATH

Reg. Dist. No. 185

Item 9 Filmcl80 4-25-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY <u>Hartford</u> 2 <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Hartford</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY OR TOWN <u>Aberdeen</u>	
TOWN <u>Hartford de Grace</u>		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>		STREET ADDRESS <u>R.D. #1</u>		DATE OF DEATH (Month) (Day) (Year)		April 11, 1955	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)		5. SEX		6. COLOR OR RACE	
Joseph A. Chalone		April 11, 1955		Male		White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		IF UNDER 1 YEAR	
Single		8/29/1891		44 63 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Self-employed Painter		House Painting		Maryland		US A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
Anton Chalone		Katherine Bozick		No		220-09-4768	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
Chas. A. Chalone Aberdeen R.D. #1-ud.		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
541.0 IMMEDIATE CAUSE (A)		Hemorrhage from duodenal ulcer		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
ANTECEDENT CAUSE(S) DUE TO				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>	
(C)				21f. HOW DID INJURY OCCUR?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		Bronchial Asthma		22. I hereby certify that I attended the deceased from April 2, 1955, to April 11, 1955, that I last saw the deceased alive on April 11, 1955, and that death occurred at 7:45 PM, from the causes and on the date stated above.		DATE SIGNED	
SIGNATURE		ADDRESS (Street, city, town, state)		23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Malcolm Dudley Phillips M.D. Darlington Md.		4/12/55		Burial		4/14/55	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
A. L. Lewis M.D.		John G. Tarrance		Bel Air Memorial Gardens		Bel Air Maryland	
DATE Apr. 16-55		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
		John G. Tarrance		Aberdeen Md.			

CERTIFICATE OF DEATH

Page No. 100

1. USUAL RESIDENCE (If not at home)

2. KIND OF DEATH

3. PLACE OF DEATH

4. SEX

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF ALDERMAN

21. SIGNATURE OF COUNCILMAN

22. SIGNATURE OF TOWNSHIP CLERK

23. SIGNATURE OF TOWNSHIP JURY

24. SIGNATURE OF TOWNSHIP JUDGE

25. SIGNATURE OF TOWNSHIP CLERK

26. SIGNATURE OF TOWNSHIP SHERIFF

27. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF

28. SIGNATURE OF TOWNSHIP CONSTABLE

29. SIGNATURE OF TOWNSHIP ALDERMAN

30. SIGNATURE OF TOWNSHIP COUNCILMAN

31. SIGNATURE OF TOWNSHIP TOWNSHIP CLERK

32. SIGNATURE OF TOWNSHIP TOWNSHIP JURY

33. SIGNATURE OF TOWNSHIP TOWNSHIP JUDGE

34. SIGNATURE OF TOWNSHIP TOWNSHIP CLERK

35. SIGNATURE OF TOWNSHIP TOWNSHIP SHERIFF

36. SIGNATURE OF TOWNSHIP TOWNSHIP DEPUTY SHERIFF

37. SIGNATURE OF TOWNSHIP TOWNSHIP CONSTABLE

38. SIGNATURE OF TOWNSHIP TOWNSHIP ALDERMAN

39. SIGNATURE OF TOWNSHIP TOWNSHIP COUNCILMAN

40. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP CLERK

41. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP JURY

42. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP JUDGE

43. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP CLERK

44. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP SHERIFF

45. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP DEPUTY SHERIFF

46. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP CONSTABLE

47. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP ALDERMAN

48. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP COUNCILMAN

49. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP TOWNSHIP CLERK

50. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP TOWNSHIP JURY

51. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP TOWNSHIP JUDGE

52. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP TOWNSHIP CLERK

53. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP TOWNSHIP SHERIFF

54. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP TOWNSHIP DEPUTY SHERIFF

55. SIGNATURE OF TOWNSHIP TOWNSHIP TOWNSHIP TOWNSHIP CONSTABLE

BUREAU V. S.

APR 18 1955

RECEIVED

RECEIVED

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3710
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03692
Reg. Dist.

No. 181

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY HARFORD		MARYLAND		STATE MASS		COUNTY unknown	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		TOWN CLINTON 58X-3	
TOWN ABERDEEN		—		STREET ADDRESS (If rural, give location)		42 FRONT ST. ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS US ROUTE #40							
3. NAME OF DECEASED: (First) PASQUALE		(Middle) J. FALLAVOLLITA		4. DATE OF DEATH April 14		19 55	
(Type or Print)							
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 18 MARCH 1934	9. AGE last birthday: 21 yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY: US ARMY		11. BIRTHPLACE (State or foreign country): MASS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: ARMAND FALLAVOLLITA				14. MOTHER'S MAIDEN NAME: ANGELINA (LAST NAME UNKNOWN)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES ✓		16. SOCIAL SECURITY No.: unknown		17. INFORMANT & ADDRESS: OFFICIAL US ARMY RECORDS			
(If Yes, give war or dates of service) 18 NOV 52 -							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<p>812X Immediate cause (a) Fracture skull DUE TO</p> <p>Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: NONE		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office hldg., etc.) US ROUTE 40		21c. (City or town) (County) Aberdeen Harford		(State) MASS.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY April 14 '55 1A.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Auto accident, auto pedestrian type			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/14/55	
M. D.		ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF 4/15/55		NAME OF CEMETERY OR CREMATORY Clinton Cemetery		LOCATION (City, town, or county) (State) Clinton, Mass.	
DATE REC'D BY LOCAL REG. April 15 - 1955		REGISTRAR'S SIGNATURE Hellie W. Perry		24. FUNERAL DIRECTOR John F. Darrington		ADDRESS Aberdeen, Mass.	

Wife Marilyn Theresa Fallavollita
42 Front St, Clinton, Mass.

BUREAU V. S.

APR 19 1955

RECEIVED

3724

Items 8, 9, Film 180 4-20-55 et

03700

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 182

1. PLACE OF DEATH:

COUNTY

Harford

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

Rutledge

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

Balto.

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN

Hyde

Rural 03X-2

STREET ADDRESS

(If rural, give location)

3. NAME OF DECEASED: (Type or Print)

(First)

(Middle)

(Last)

FRANCIS WALTER GAITHER

4. DATE OF DEATH

(Month)

(Day)

(Year)

4 2 19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

Male

col

MARRIED

JULY 26 1928

26 yrs.

9 11 26

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Truck driver John F. Lewis & Co

Sodding

Canollco Md

USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Evan Gaither

Virginia Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

yes

world war 2

Evan Gaither Hyde Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) STAB Wound of Pulmonary ARTERY

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

SIGNATURE

R. Fisher

CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.

DATE SIGNED 4-20-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-4-55

Nuvella Ford road

Martin G. King

Lanettville

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED APR 11 1955

RECEIVED APR 11 1955

RECEIVED APR 11 1955

BUREAU V. S.

APR 11 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

3725		MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18		03701	
CERTIFICATE OF DEATH					
Reg. Dist. No.....					
1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <u>Harford</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Harford</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		
TOWN <u>Aberdeen</u>			TOWN <u>Aberdeen</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Army Hospital</u>			STREET ADDRESS (If rural give location) <u>146 Banister Ave</u>		
3. NAME OF DECEASED (Type or Print) <u>MARY LOUISE GAUMER</u>			4. DATE OF DEATH <u>April 14 1955</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>---</u>			8. DATE OF BIRTH <u>13 APR 55</u>		
9. AGE last birthday <u>1</u> yrs.			10. IF UNDER 1 YEAR <u>1</u> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Merle GAUMER</u>			14. MOTHER'S MAIDEN NAME <u>Jacqueline Betty Spencer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>			16. SOCIAL SECURITY NO. <u>---</u>		
17. INFORMANT & ADDRESS <u>Merle W. Gaumer</u>			<u>146 Banister Ave, Aberdeen, Md</u>		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH <u>32 hrs</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>					
ANTECEDENT CAUSE(S) DUE TO (B) <u>None</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>---</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>---</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12 APR 1955</u> to <u>14 APR 1955</u> , that I last saw the deceased alive on <u>12 APR 1955</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Richard Allen</u>		ADDRESS (Street, city, town, state) <u>M.D. U.S. Army Hosp, Aberdeen Proving Ground, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>16 APR 55</u>		NAME OF CEMETERY OR CREMATORY <u>ARMED FORCES INSTITUTE OF PATHOLOGY</u>	
LOCATION (City, town, or county) <u>WASHINGTON D.C.</u>		(State) <u>---</u>			
24. REC'D BY REGISTRAR <u>4/19/55</u>		REGISTRAR'S SIGNATURE <u>Nellie R. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Perry</u>	
DATE		ADDRESS <u>APG, Md</u>			

2045343240

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3726 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03702

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WHITEFORD</u>			
X TOWN <u>RURAL - STREET</u>		3 WKS.		STREET ADDRESS (If rural give location) <u>1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>DOLLIE MATILDA GLASGOW</u>				<u>APR. 19, 1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>SEPT. 27, 1866</u>	
						9. AGE last birthday <u>88</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>YORK CO., PA.</u>	
13. FATHER'S NAME: <u>ELLIS LARUE</u>				14. MOTHER'S MAIDEN NAME: <u>MARY BURKENTINE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>ELSIE M. EVANS, DELTA, PA.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>
ANTECEDENT CAUSE (S) DUE TO <u>Coronary Atherosclerosis</u>							IMMEDIATE CAUSE (B) <u>Arterio Sclerotic C.V. Disease</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arterio Sclerotic C.V. Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>1939</u> , to <u>April 19, 1955</u> , that I last saw the deceased alive on <u>April 10, 1955</u> , and that death occurred at <u>98</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Jonah G. Hunt</u>				ADDRESS <u>Delta, Pa.</u>		DATE SIGNED <u>4/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APR. 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		LOCATION (City, town, or county) (State) <u>DELTA, YORK CO., PA.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/21/55</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>			24. FUNERAL DIRECTOR ADDRESS <u>JOHN H. HARKINS, DELTA, PA.</u>		

BUREAU V. S.

APR 26 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3711

03703

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Cecil</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		TOWN <u>Port Deposit</u>	
CITY OR TOWN <u>Harford</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>Box 17</u>		(If rural give location) <u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Janet Marie Hayes</u>				<u>April 13 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Nov. 6, 1954</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>5</u> yrs.		IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Frederick X. Hayes</u>				14. MOTHER'S MAIDEN NAME <u>Frances McCloud</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Frances Hayes (Mother)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
491X IMMEDIATE CAUSE (A) <u>Breast / Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-12</u> , 19 <u>55</u> , to <u>4-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-13</u> , 19 <u>55</u> , and that death occurred at <u>9:00</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Box 17, Port Deposit, Md.</u>		DATE SIGNED <u>4-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. R.D.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Perryville, Md.</u>	
DATE <u>Apr. 13-1955</u>							

10X4317364

CERTIFICATE OF DEATH

371

Reg. Dist. No. 1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE

11. SIGNATURE

12. SIGNATURE

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BUREAU V. B.

APR 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03704

3727

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Aberdeen</u>		LENGTH OF STAY (In this place) <u>9 1/2 hours</u>		OR TOWN <u>Edgewood</u>		OR TOWN <u>Edgewood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital Aberdeen Proving Ground Md</u>				STREET ADDRESS (If rural give location) <u>22 Morgan Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARY LYN HIMMLER</u>				<u>April 30 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>29 April 1955</u>	<u>9</u>	<u>30</u>	<u>9</u>	<u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>none</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William A Himmler</u>				<u>Theresa E Callahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS (father) <u>William A Himmler 22 Morgan St Edgewood Md</u>			
<u>no</u>		<u>none</u>					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 1/2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 Apr</u>, 19 <u>55</u>, to <u>30 Apr</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>30 Apr</u>, 19 <u>55</u>, and that death occurred at <u>12:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Richard Allen</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>M.D. US Army Hospital Aberdeen PG Md</u>		<u>30 April 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/3/55</u>		<u>Post Cemetery</u>		<u>A.R.C. (Edgewood) Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 3-55</u>		<u>Hellie G. Perry</u>		<u>John G. Tarring</u>		<u>Aberdeen Md.</u>	

20405232260

CERTIFICATE OF DEATH

Form 10-1-34

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. RACE

5. DATE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF VENDOR

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

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NOTICE

RECEIVED
MAY 5 1934
BUREAU V. S.

3728

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY OR TOWN Abingdon		LENGTH OF STAY (in this place) lifetime		CITY OR TOWN Abingdon			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Loudon		(Middle) G.		(Last) Hooker		(Month) APRIL (Day) 18 (Year) 1953	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH JAN 22 1893	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner, agriculture		11. BIRTHPLACE (State or foreign country) Abingdon, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward G. Hooker				14. MOTHER'S MAIDEN NAME Lula Grafton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs. Katherine Hooker, Edgewood, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Acute left ventricular failure						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days	
ANTECEDENT CAUSE(S) DUE TO Bronchial asthma						12 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Hypertensive cardiovascular disease						12 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7 Aug , 19 53 , to 18 Apr , 19 53 , that I last saw the deceased alive on 18 Apr , 19 53 , and that death occurred at 2:30 P. M, from the causes and on the date stated above.							
SIGNATURE H. K. McComas		M. D.		ADDRESS (Street, city, town, state) Baltimore, Md		DATE SIGNED 18 Apr 53	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 20, 1955		NAME OF CEMETERY OR CREMATORY St. Francis		LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
24. REC'D BY REGISTRAR Apr. 21, 1955		REGISTRAR'S SIGNATURE Norma E. Moore		25. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son, Abingdon, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3712

CERTIFICATE OF DEATH

03706

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY OR TOWN <u>24 HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>50 YRS.</u>		CITY OR TOWN <u>HAVRE DE GRACE</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>721 OTSEGO ST.</u>				STREET ADDRESS <u>721 OTSEGO ST.</u>		(If rural give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>ALICE DUNSTON JOBES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>APR. 3 1955</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>AUG. 1, 1875</u>	
9. AGE last birthday <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME - RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>(UNKNOWN) DUNSTON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>MR. DONALD K. JOBES</u>		18. MEDICAL CERTIFICATION <u>HAVRE DE GRACE, MD.</u>		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		260X IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>		260X ANTECEDENT CAUSE(S) DUE TO (B) <u>Uremia - (2 days) Arteriosclerotic cardiovascular</u>		1 day	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Diabetes Mellitus - Arteriosclerotic</u>		5 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>June 1950</u> , to <u>April 1955</u> , that I last saw the deceased alive on <u>April 3, 1955</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John W. Weichert</u>		M.D. <u>Havre de Grace</u>		ADDRESS (Street, city, town, state) <u>April 6, 1955</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APR. 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE, MD</u>	
24. REC'D BY REGISTRAR <u>W. L. R. Madison Mitchell</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

MARYLAND

LOCALITY OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of State Registrar

Signature of State Coroner

Signature of State Medical Examiner

Signature of State Health Officer

Signature of State County Clerk

Signature of State Registrar

Signature of State Coroner

Signature of State Medical Examiner

Signature of State Health Officer

Signature of State County Clerk

Signature of State Registrar

Signature of State Coroner

Signature of State Medical Examiner

Signature of State Health Officer

Signature of State County Clerk

Signature of State Registrar

Signature of State Coroner

Signature of State Medical Examiner

Signature of State Health Officer

Signature of State County Clerk

Signature of State Registrar

Signature of State Coroner

Signature of State Medical Examiner

Signature of State Health Officer

Signature of State County Clerk

Signature of State Registrar

Signature of State Coroner

Signature of State Medical Examiner

Signature of State Health Officer

Signature of State County Clerk

Signature of State Registrar

Signature of State Coroner

Signature of State Medical Examiner

Signature of State Health Officer

BUREAU V. S.

APR 11 1955

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND
APR 11 1955
RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3729

CERTIFICATE OF DEATH

03707

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>X</i> <i>Wilmington</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>X</i> <i>Wilmington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	<i>1</i>
3. NAME OF DECEASED (Type or Print) <i>Estella Knight</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>April 5 1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Jan 21 1866</i>
9. AGE last birthday <i>89</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harrison Fink</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Knight</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>183-09-004</i>	
17. INFORMANT & ADDRESS <i>Dr. W. W. Warner, Pkwy</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <i>CARCINOMA of Rectum</i>		<i>2 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21c. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 55, to April 5, 1955, that I last saw the deceased alive on April 5, 1955, and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
SIGNATURE <i>Malcolm Dudley Phillips</i>		ADDRESS (Street, city, town, state) <i>Wilmington Md</i>	
DATE <i>April 18 1955</i>		DATE SIGNED <i>4/17/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Warner</i>	
DATE <i>April 18 1955</i>		ADDRESS <i>Wilmington Md</i>	

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 18 Film G180 4-15-55 ams

3713

CERTIFICATE OF DEATH

03708

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Hartford</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
24 <u>Hartford</u>				31 <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
71 <u>Hartford Memorial Hospital</u>				<u>74 Normen Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Ralph David Kobashigawa</u>				<u>April 5 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>INFANT</u>	<u>7/18/54</u>	<u>—</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>INFANT</u>		<u>INFANT</u>		<u>Maryland</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Sgt. Yoshio Kobashigawa</u>				<u>Irene Flou.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Yoshio Kobashigawa - Aberdeen Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
571.0 IMMEDIATE CAUSE (A)				<u>Acute Infection</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Non-specific enteritis.</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/5</u> , 19 <u>55</u> , to <u>4/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/5</u> , 19 <u>55</u> , and that death occurred at <u>6:05 P.</u> M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Richard J. Statten</u>				<u>17 N. Phila. Blvd. Aberdeen, Md. 4/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/7/55</u>		<u>Post Cemetery APC.</u>		<u>Aberdeen Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Apr 7-1955</u>		<u>A. L. Lewis M.D.</u>		<u>John G. Tarrany</u>		<u>Aberdeen Md.</u>	

2074263415

CERTIFICATE OF DEATH

A. USUAL RESIDENCE (NAME OF DECEASED)

MARYLAND
COUNTY OF

11-1-1955

B. PLACE OF DEATH

54 N. ...

C. DATE OF DEATH

11-1-1955

D. TIME OF DEATH

...

E. CAUSE OF DEATH

...

F. MANNER OF DEATH

...

G. SIGNATURE OF DECEASED

...

H. SIGNATURE OF WITNESSES

...

I. SIGNATURE OF PHYSICIAN

...

J. SIGNATURE OF REGISTRAR

...

K. SIGNATURE OF CLERK

...

BUREAU V. S.

APR 11 1955

RECEIVED

1

INSTRUCTIONS

1 The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03709

3714

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Veel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAURE DE GRACE</u>		LENGTH OF STAY (in this place) <u>8 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>part Deposit</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hosp.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>FRANK</u> (First) <u>A</u> (Middle) <u>KRAUSE</u> (Last)				4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Jan. 7-1863</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN KRAUSE</u>				14. MOTHER'S MAIDEN NAME <u>CAROLYN LADWIG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mrs Arthur MacArthur</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
572.1 IMMEDIATE CAUSE (A) <u>Shock - post operative</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Obstruction due to diverticulitis</u>						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cardiac Failure</u>							
19a. DATE OF OPERATION <u>4-11-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Selected Obstruction due to diverticulitis of cecum</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.							
SIGNATURE <u>Wm. K. Stender</u>				DATE SIGNED <u>4-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-15-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Norcross, Iowa</u>	
24. REC'D BY REGISTRAR <u>Apr. 12 - 1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Veel Patterson & Son, Perryville, Md.</u>			

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03710

3715

CERTIFICATE OF DEATH

Reg. Dist. No. 186

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		TOWN <u>Bel Air</u>	
CITY OR TOWN <u>Harre-des-Chace</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>R. F. D.</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>							
3. NAME OF DECEASED (Type or Print) <u>John Naval Lewis</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-1-1901</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed due to illness</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John H. Lewis</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Daughter Rose Lee Street, Md</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
162X IMMEDIATE CAUSE (A) <u>Carcinomatous</u>				<u>7 wks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchogenic Carcinoma - Left</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/13, 1955</u> , to <u>4/19, 1955</u> , that I last saw the deceased alive on <u>4/19, 1955</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frederick J. Hinton</u> M.D.				ADDRESS (Street, city, town, state) <u>17 N. Main Blvd. Bel Air, Md</u>		DATE SIGNED <u>4/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel</u>		LOCATION (City, town, or county) (State) <u>Harford Co Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>U. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Dorlington Md.</u>	
DATE <u>Apr. 20-55</u>							

3730

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>RURAL-PYLESVILLE</u>				OR TOWN <u>RURAL PYLESVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				<u>PYLESVILLE RD</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)				
<u>WILLIAM W. LINKOUS</u>			<u>APRIL 24 1955</u>				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.			
<u>M</u>	<u>W</u>		<u>2-2-1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMER</u>			<u>OWN FARM</u>	<u>VIRGINIA</u>		<u>USA.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>WILLIAM LINKOUS</u>				<u>JANE CECIL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:			
				<u>Everett Sinkov Pylesville Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>422.1 Immediate cause (a) <u>Chronic Myocarditis</u></p> <p>Antecedent causes (s) (b) <u>Arteriosclerosis</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)</p>							
Interval Between Onset And Death ?							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 5, 1955</u> , to <u>April 23, 1955</u> , that I last saw the deceased alive on <u>April 23, 1955</u> , and that death occurred at <u>9 15 PM</u> , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Edward H. Hyson M.D.</u>				<u>4/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>4-27-55</u>		<u>HIGHLAND PRESBY</u>		<u>STREET, HARFORD CO., MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4/26/55</u>		<u>Priscilla Lowndes</u>		<u>Edward H. Hyson</u>		<u>Town Green Pa</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3731

03712

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 180

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Harford		MARYLAND		STATE Maryland COUNTY Cecil			
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Edgewood R.D.		LENGTH OF STAY (in this place) 2 weeks		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cecilton 07X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) Minnie Florence (Middle) Long (Last)				(Month) April (Day) 23 (Year) 1955			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH: Oct. 5, 1878	9. AGE last birth day: 76 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY: none		11. BIRTHPLACE (State or foreign country): Cecil Co., Md.		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: George Fithian				14. MOTHER'S MAIDEN NAME: unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: none		17. INFORMANT & ADDRESS: Mrs. Wm., C. Latham, Edgewood, Maryland			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
422.1 Immediate cause (a) Pulmonary edema DUE TO							
Antecedent cause(s) (b) Arteriosclerotic C.V. disease Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Lord C Palmer		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/23/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Apr. 27, 1955		NAME OF CEMETERY OR CREMATORY Cecilton		LOCATION (City, town, or county) (State) Cecilton, Cecil, Md	
DATE REC'D BY LOCAL REG. Apr. 25, 1955		REGISTRAR'S SIGNATURE Norma G. Moore		24. FUNERAL DIRECTOR Edward Fellows, Cecilton		ADDRESS Md	

BUREAU V. S.

APR 27 1925

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03713 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>5 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		R.F.D. <u>3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 326 Vale Road</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Lawrence</u>		(Middle) <u>F.</u>		(Last) <u>Lutz</u>		(Month) <u>April 9,</u> (Day) <u>19</u> (Year) <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>August 7, 1872</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier - Retired Balto. Transit Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brooklyn, N.Y.</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Lutz</u>				14. MOTHER'S MAIDEN NAME <u>Victoria unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>John A. Lutz R.F.D. 3 Bel Air, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
422.1 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure, terminating</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr Cardio-vascular Disease with decompensation</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Parkinson's Disease.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							1 yr.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>50</u> , to <u>April 9,</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 8,</u> , 19 <u>55</u> , and that death occurred at <u>10:20 A.M.</u> on the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u>				DATE SIGNED <u>4-10-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>4-13-55</u>		REGISTRAR'S SIGNATURE <u>L</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc.</u> ADDRESS <u>6009 Harford Road</u>			

[illegible]

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674 5th - 10th St.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03714

3732

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>RURAL-HAVRE DE GRACE</u>		<u>5 YRS.</u>		TOWN <u>RURAL-HAVRE DE GRACE</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>		<u>R.D. #2</u>		<u>R.D. #2</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>BESSIE</u> (Middle) <u>VANSANT</u> (Last) <u>MACKLEM</u>				(Month) <u>APR.</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>SEPT. 5, 1880</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Secretary</u>		<u>RETIRED</u>		<u>WIL. DELAWARE</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN M. MACKLEM</u>				<u>ELIZABETH DAVIES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>MISS SARAH L. MACKLEM</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1747 IMMEDIATE CAUSE (A)				<u>HAVRE DE GRACE, MD.</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Carcinoma of uterine (Retro) Metastasis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-4</u> , 19 <u>54</u> , to <u>7-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Apr 4</u> , 19 <u>55</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>G. L. Lewis M.D.</u>				ADDRESS (Street) city, town, state DATE SIGNED <u>Apr. 6-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>APR. 7, 1955</u>		<u>Rock Run Cem.</u>		<u>HARFORD MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Apr 6-1955</u>		<u>G. L. Lewis M.D.</u>		<u>R. Madison Mitchell</u>		<u>HAVRE DE GRACE MD.</u>	

CERTIFICATE OF DEATH

Form 100-1

TO BE COMPLETED BY THE REGISTRAR

STATE OF MARYLAND

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

BUREAU V. S.

APR 11 1911

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03715

3733

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Aberdeen R.D.		LENGTH OF STAY (in this place) Lifetime		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Aberdeen R.D.		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03				STREET ADDRESS (If rural give location) Churchville			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) James (Middle) Allen (Last) Mahan				(Month) Apr. (Day) 15 (Year) 19 55			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH June, 28, 1880	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Philip Mahan				14. MOTHER'S MAIDEN NAME Angeline Virginia Baily			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 216-10-6839		17. INFORMANT & ADDRESS Allen L. Mahan, H avre de Grace, Md.,			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) Arterio-sclerotic C-P Disease				8 yrs			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Multiple Sclerosis				10 yrs			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 11, 19 52 , to April 15, 19 55 , that I last saw the deceased alive on April 15, 19 55 , and that death occurred at 11 P M, from the causes and on the date stated above.							
SIGNATURE Ralph H. H. H.				ADDRESS (Street, city, town, state) Churchville Md		DATE SIGNED April 17	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 18, 1955		NAME OF CEMETERY OR CREMATORY Smith's Chapel		LOCATION (City, town, or county) (State) Churchville, Harford, Md.	
24. REC'D BY REGISTRAR April 18-1955		REGISTRAR'S SIGNATURE William G. Perry		25. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son, Abingdon, Md.		ADDRESS Howard K. McComas Jr	

CERTIFICATE OF DEATH

Reg. No. 12

NAME OF DECEASED JAMES H. HARRIS	DATE OF BIRTH JAN 15 1888	PLACE OF BIRTH BALTIMORE, MD
RESIDENCE BALTIMORE, MD	DATE OF DEATH APR 22 1955	PLACE OF DEATH BALTIMORE, MD
CAUSE OF DEATH CORONARY THROMBOSIS		

SEX Male	RACE White	EDUCATION High School
RELIGION Roman Catholic	PROFESSION None	DATE OF MARRIAGE None
MANNER OF DEATH Natural		

NAME OF PHYSICIAN JAMES H. HARRIS	DATE OF EXAMINATION APR 22 1955	PLACE OF EXAMINATION BALTIMORE, MD
SIGNATURE OF PHYSICIAN JAMES H. HARRIS		

BUREAU V. S.

APR 22 1955

RECEIVED

3734

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u> <u>Darlington, Rural</u>	LENGTH OF STAY (in this place) <u>1 yr</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Port Deposit, Md. Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Woodlawn</u>	<u>07X-2</u>
3. NAME OF DECEASED: (Type or Print) <u>William S. (First) (Middle) (Last) McFadden</u>		4. DATE OF DEATH: (Month) <u>April</u> (Day) <u>1</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec. 22, 1876</u>
9. AGE last birthday: <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Kabaker</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>dry</u>	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George McFadden</u>		14. MOTHER'S MAIDEN NAME: <u>Lovelphine Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>214-20-4419</u>	
17. INFORMANT & ADDRESS: <u>Eva Curry, Port Deposit, Md</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
450.0 Immediate cause (a) <u>Congestive Heart Failure</u>		<u>2 wks</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>arteriosclerosis Generalized</u>		<u>2 yr</u>	
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 19, 1955</u> , to <u>April 1, 1955</u> , that I last saw the deceased alive on <u>March 29, 1955</u> , and that death occurred at <u>6:00 pm</u> from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>Madison Dudley Phillips, M.D.</u>		ADDRESS <u>Darlington, Md</u> DATE SIGNED <u>4/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-4-1955</u>	<u>St. Agnes</u>	<u>Port Deposit, Md. Rural</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>April 1, 1955</u>	<u>C. B. Kirk</u>	<u>W. A. Patterson & Son, Perryville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 12 1955

RECEIVED

3735

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pylesville P.O.</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pylesville P.O.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<i>Charles E. Morrison</i>		<i>April 15 1955</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>Aug 4, 1881</i>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Farmer and Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Pa</i>
13. FATHER'S NAME: <i>Thomas Morrison</i>		14. MOTHER'S MAIDEN NAME: <i>Ellen Hodges</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY No.: <i>none</i>	
17. INFORMANT & ADDRESS: <i>Teresa Morrison Pylesville Md</i>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X Immediate cause (a) <i>Cerebral Hemorrhage</i>		<i>10 days</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Coronary insufficiency</i>		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE	OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>April 15, 1955</i> , to <i>April 15, 1955</i> , that I last saw the deceased alive on <i>April 14, 1955</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.		
SIGNATURE (Degree or title) <i>Edward H. Hyman MD</i>		DATE, SIGNED <i>4/15/55</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>April 15 1955</i>	<i>St Marys Pylesville Md</i>
DATE RECD BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<i>4/16/55</i>	<i>Rueella Lowndes</i>	<i>W. Howard Webb Town Line Pa</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 19 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03718

3736

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>BEL AIR MD</u> (At) <u>WORK</u>				TOWN <u>Benson (Rural) MD</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
00 <u>Employed BEL AIR, MD</u>				<u>BEL AIR ROAD</u>		1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Charles Brown NEIKIRK</u>				<u>April 28 - 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>Feb 26 - 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>CLERK Gas Filling Station</u>				<u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James W Neikirk</u>				<u>Elizabeth V Pierce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>215-07-4017</u>		<u>Fallston MD</u>			
				<u>Mrs C Brown Neikirk RDR</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerosis, generalized</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Peptic ulcer</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1950</u> , to <u>APRIL 28, 1955</u> , that I last saw the deceased alive on <u>APRIL 28, 1955</u> , and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Paul S. Stornes Jr.</u>				<u>115 Fulton Ave. Bel Air, Md. 4/28/55</u>			
M.D. <u>115 Fulton Ave. Bel Air, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 1/55</u>		<u>MT Zion</u>		<u>Fountain Green Hartford MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5/4/55</u>		<u>Priscilla Forward</u>		<u>Joseph Foster Bel Air Md</u>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3716

CERTIFICATE OF DEATH

03719

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <u>Harford</u> <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u> <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u> STREET ADDRESS (If rural give location) <u>565 Congress</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>George</u> (Middle) <u>A.</u> (Last) <u>Nichols</u>				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/13/1903</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charles Barker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Harford</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lamorne N. Nichols</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Whithead</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Mr. Ernest F. Nichols, Harford, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>163X IMMEDIATE CAUSE (A) <u>Carcinoma Lung</u></u>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinomatosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cachexia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 19 55</u> to <u>April 30 55</u> , that I last saw the deceased alive on <u>4/30</u> , 19 <u>55</u> , and that death occurred at <u>7A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Fly</u> M.D.				ADDRESS (Street, city, town, state) <u>Harford, Md.</u> DATE SIGNED <u>5/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>5/5/55</u>	NAME OF CEMETERY OR CREMATORY <u>Wright Hill</u>		LOCATION (City, town, or county) (State) <u>Harford, Md.</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Fly</u> ADDRESS <u>Harford, Md.</u>			
DATE <u>May 2 - 1955</u>							

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3737

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03720

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HARFORD.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural (Monkton)</u>		LENGTH OF STAY (in this place) <u>86 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Monkton).</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pocock Rd - Monkton.</u>				STREET ADDRESS (If rural give location) <u>Monkton (Pocock Rd)!</u>		X	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HARRY GILMORE POCOCK</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APR 23 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>3 June 1868</u>	9. AGE last birthday <u>86(86)</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FARMER</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Harford Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>JESSE POCOCK</u>				14. MOTHER'S MAIDEN NAME: <u>ELLEN BEATTY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Mrs. H. G. Pocock, Monkton, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pneumonia, hypostatic</u>						<u>2 days</u>	
ANTECEDENT CAUSE (B) <u>Arterio Sclerotic Heart Disease</u>						<u>10 years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Rheumatic Heart Disease</u>						<u>60 years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> ..., 19 <u>55</u> , to <u>23 Apr.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>23 Apr.</u> , 19 <u>54</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Thomas A. E. Mosley Jr. M.D.</u>		ADDRESS <u>Pylesville Md.</u>		DATE SIGNED <u>23 Apr 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr 26 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		LOCATION (City, town, or county) (State) <u>Pylesville, Harford Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/27/55</u>		REGISTRAR'S SIGNATURE <u>Russella Lowwood</u>		24. FUNERAL DIRECTOR <u>Martin E. ...</u>		ADDRESS <u>...</u>	

BUREAU V. S.

APR 29 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03721

3717

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harford de Meace</u> LENGTH OF STAY (in this place) <u>1 day</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel-Air</u> STREET ADDRESS (If rural give location) <u>4 Bond Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Pamela</u> (First) <u>Arlene</u> (Middle) <u>Presbury</u> (Last) 4. DATE OF DEATH (Month) <u>April</u> (Day) <u>17</u> (Year) <u>1955</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>negro</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u> 8. DATE OF BIRTH <u>April 16, 1955</u> 9. AGE last birthday <u>—</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>4</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>Johnnie Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frances Presbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>mother</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
762.0 IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congenital Cystic Disease of Lung</u>						<u>28 hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/> 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>April 16, 1955</u> , to <u>Apr 17, 1955</u> , that I last saw the deceased alive on <u>Apr 17, 1955</u> , and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Fredrick J. Stater</u> M.D. <u>177 North Blvd. Baltimore Md</u>				ADDRESS (Street, city, town, state) <u>Harford de Meace, Md.</u> DATE SIGNED <u>4/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. James A.M.E. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Harford de Meace, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stella J. Bullock</u>		ADDRESS <u>Harford de Meace, Md.</u>	
DATE <u>Apr. 19-55</u>							

2045254414

CERTIFICATE OF DEATH

REG. NO. 100-100

A. NAME OF DECEASED (Print or Write)

MARYLAND

1. PLACE OF DEATH

B. SEX (Print or Write)

MALE

2. AGE (Print or Write)

C. RACE (Print or Write)

WHITE

3. DATE OF DEATH (Print or Write)

D. TIME OF DEATH (Print or Write)

10:00 AM

4. PLACE OF BIRTH (Print or Write)

E. DATE OF BIRTH (Print or Write)

1900

5. PLACE OF DEATH (Print or Write)

F. TIME OF DEATH (Print or Write)

10:00 AM

6. PLACE OF BIRTH (Print or Write)

G. DATE OF BIRTH (Print or Write)

1900

7. PLACE OF DEATH (Print or Write)

H. TIME OF DEATH (Print or Write)

10:00 AM

8. PLACE OF BIRTH (Print or Write)

I. DATE OF BIRTH (Print or Write)

1900

9. PLACE OF DEATH (Print or Write)

J. TIME OF DEATH (Print or Write)

10:00 AM

10. PLACE OF BIRTH (Print or Write)

K. DATE OF BIRTH (Print or Write)

1900

11. PLACE OF DEATH (Print or Write)

L. TIME OF DEATH (Print or Write)

10:00 AM

12. PLACE OF BIRTH (Print or Write)

M. DATE OF BIRTH (Print or Write)

1900

13. PLACE OF DEATH (Print or Write)

N. TIME OF DEATH (Print or Write)

10:00 AM

14. PLACE OF BIRTH (Print or Write)

O. DATE OF BIRTH (Print or Write)

1900

15. PLACE OF DEATH (Print or Write)

P. TIME OF DEATH (Print or Write)

10:00 AM

16. PLACE OF BIRTH (Print or Write)

Q. DATE OF BIRTH (Print or Write)

1900

17. PLACE OF DEATH (Print or Write)

R. TIME OF DEATH (Print or Write)

10:00 AM

18. PLACE OF BIRTH (Print or Write)

S. DATE OF BIRTH (Print or Write)

1900

19. PLACE OF DEATH (Print or Write)

T. TIME OF DEATH (Print or Write)

10:00 AM

20. PLACE OF BIRTH (Print or Write)

U. DATE OF BIRTH (Print or Write)

1900

21. PLACE OF DEATH (Print or Write)

V. TIME OF DEATH (Print or Write)

10:00 AM

22. PLACE OF BIRTH (Print or Write)

W. DATE OF BIRTH (Print or Write)

1900

23. PLACE OF DEATH (Print or Write)

X. TIME OF DEATH (Print or Write)

10:00 AM

24. PLACE OF BIRTH (Print or Write)

Y. DATE OF BIRTH (Print or Write)

1900

25. PLACE OF DEATH (Print or Write)

Z. TIME OF DEATH (Print or Write)

10:00 AM

26. PLACE OF BIRTH (Print or Write)

AA. DATE OF BIRTH (Print or Write)

1900

27. PLACE OF DEATH (Print or Write)

AB. TIME OF DEATH (Print or Write)

10:00 AM

28. PLACE OF BIRTH (Print or Write)

AC. DATE OF BIRTH (Print or Write)

1900

29. PLACE OF DEATH (Print or Write)

AD. TIME OF DEATH (Print or Write)

10:00 AM

30. PLACE OF BIRTH (Print or Write)

AE. DATE OF BIRTH (Print or Write)

1900

31. PLACE OF DEATH (Print or Write)

AF. TIME OF DEATH (Print or Write)

10:00 AM

32. PLACE OF BIRTH (Print or Write)

AG. DATE OF BIRTH (Print or Write)

1900

33. PLACE OF DEATH (Print or Write)

AH. TIME OF DEATH (Print or Write)

10:00 AM

34. PLACE OF BIRTH (Print or Write)

AI. DATE OF BIRTH (Print or Write)

1900

35. PLACE OF DEATH (Print or Write)

AJ. TIME OF DEATH (Print or Write)

10:00 AM

36. PLACE OF BIRTH (Print or Write)

AK. DATE OF BIRTH (Print or Write)

1900

37. PLACE OF DEATH (Print or Write)

AL. TIME OF DEATH (Print or Write)

10:00 AM

38. PLACE OF BIRTH (Print or Write)

AM. DATE OF BIRTH (Print or Write)

1900

39. PLACE OF DEATH (Print or Write)

AN. TIME OF DEATH (Print or Write)

10:00 AM

40. PLACE OF BIRTH (Print or Write)

BUREAU V. S.

APR 21 1955

RECEIVED

EXHIBIT

2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03722

3738

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Kingsville</u>		<u>50 yrs</u>		TOWN <u>Kingsville Md</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>Jerusalem</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Harry</u> (Middle) <u>Summerville</u> (Last) <u>Pyle</u>				april 25 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>May 2, 1863</u>	<u>91</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>General</u>		<u>Chestnut Hill Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Amer Pyle</u>				<u>Mary Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>no</u>				<u>none</u>		<u>Erason Pyle</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>C. of Rectum</u>				<u>1 1/2 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March, 1955</u> , to <u>April 25, 1955</u> , that I last saw the deceased alive on <u>April 25, 1955</u> , and that death occurred at <u>7:50</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city, town, state) <u>Kingsville, Md.</u>		DATE SIGNED <u>4-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 28, 1955</u>		<u>Mountain Christian</u>		<u>Esppa Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5/2/56</u>		<u>Wm. L. Toward</u>		<u>W. H. Greber</u>		<u>Benson, Md</u>	

1997-02-09

Instructions

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03723

3718

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>31 Aberdeen</u>		LENGTH OF STAY (in this place) <u>4 yrs.</u>		CITY OR TOWN <u>Aberdeen</u>		31	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 461 W. Bel Air Ave.</u>				STREET ADDRESS <u>461 W. Bel Air Ave.</u>		(If rural give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Grace</u>		(Middle) <u>May</u>		(Last) <u>Reed</u>		(Month) <u>7</u> (Day) <u>30</u> (Year) <u>19 55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 27th 1876</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>	
13. FATHER'S NAME <u>Orland T. Haight</u>				14. MOTHER'S MAIDEN NAME <u>Sarah M. Becker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT & ADDRESS <u>Alice B. Reed - 461 W. Bel Air Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <u>Inanition</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Thrombosis</u>						<u>10 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Cerebral Arteriosclerosis</u>						<u>5 yr</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 50</u> , to <u>4-30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-29</u> , 19 <u>55</u> , and that death occurred at <u>5:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John P. Coleman</u>		M.D. <u>Aberdeen Md.</u>		ADDRESS (Street, city, town, state) <u>5-2-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		LOCATION (City, town, or county) (State) <u>Aberdeen, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Willis R. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Tarring</u>		ADDRESS <u>Aberdeen Md.</u>	
DATE <u>May 3-55</u>							

CERTIFICATE OF DEATH

State of New York

County of New York

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

SIGNATURE OF REGISTRAR

SIGNATURE OF WITNESS

SIGNATURE OF DECEASED

SIGNATURE OF NEXT OF KIN

SIGNATURE OF PHYSICIAN

SIGNATURE OF CLERGYMAN

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF CLERK

SIGNATURE OF NOTARY

BUREAU V. S.

MAY 5 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3719

03724

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Hagerford County</i>		MARYLAND		STATE <i>Pa</i>		COUNTY <i>Chester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <i>Harve de Grace</i>				TOWN <i>rural - upper Ox for d</i>		<i>75X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hartford Memorial Hosp</i>				STREET ADDRESS (If rural give location) <i>Lincoln University Pa</i>			
3. NAME OF DECEASED (Type or Print) <i>Thomas C Sellers</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>April 11, 1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>May 5, 1894</i>	9. AGE last birthday <i>60</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Telegrapher</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>P.R.</i>	11. BIRTHPLACE (State or foreign country) <i>Oxford Pa</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Thomas Sellers</i>				14. MOTHER'S MAIDEN NAME <i>Anna Hackman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i> (If Yes, give war or dates of service) <i>World War I</i>			16. SOCIAL SECURITY NO. <i>717-07-5737</i>		17. INFORMANT & ADDRESS <i>Howard Sellers - Oxford Pa.</i>		
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Cardiovascular Disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arteriosclerotic Cardiovascular Disease</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 10:20 PM, from the causes and on the date stated above.							
SIGNATURE <i>Charles J. Foley M.D.</i>				ADDRESS (Street, city, town, state) <i>1400 N. 1st St. Baltimore Md</i> DATE SIGNED <i>4/11/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Apr. 15, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Oxford Cem.</i>		LOCATION (City, town, or county) (State) <i>Oxford Chester Co. Pa</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed</i>		ADDRESS <i>Rising Sun Md</i>	
DATE <i>Apr. 14 - 1955</i>							

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03725

3739

CERTIFICATE OF DEATH

Reg. Dist. No. 182

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bell Air Rural</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bell Air Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <i>Bertina S Shure</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>April 6, 1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>May 8, 1865</i>
9. AGE last birthday <i>89</i> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <i>89</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker at Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Harford Co. Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Albas S. Carborough</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Bishop</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT & ADDRESS <i>Miss Catherine S. Carborough</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Mar 31, 1955</i>, to <i>April 6, 1955</i>, that I last saw the deceased alive on <i>April 5, 1955</i>, and that death occurred at <i>4:17 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>E. P. Snodgrass</i>		DATE SIGNED <i>4/9-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR	
DATE OF <i>April 8, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Harford Co. Md.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Bailey</i>		ADDRESS <i>Wilmington, Md.</i>	

Abraham Lincoln

Chas. J. Davis & Co.

BUREAU V. S.

28 APR 14 1955

Handwritten signature: *James E. ...*

22-2

May 1901

1922

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03726

3740

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>		TOWN <u>Hunterdon</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Aberdeen</u>		LENGTH OF STAY (in this place) <u>47 hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> <u>Edgewood</u> <u>Lebanon</u> <u>67X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50</u> <u>US Army Hospital</u> <u>Aberdeen Proving Ground Md</u>		STREET ADDRESS (If rural give location) <u>General Delivery</u> <u>R. F. D.</u> <u>3</u> <u>✓</u>					
3. NAME OF DECEASED (Type or Print) <u>DEBORAH ALISON STOBB</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>26</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 24 1955</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rudolph Charles Stobb</u>				14. MOTHER'S MAIDEN NAME <u>Sally Hope Bloomfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS (Father) <u>Rudolph C Stobb</u> <u>Gen Dely Edgewood Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>776X</u> <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>47 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>24 Apr.</u> , 19 <u>55</u> , to <u>26 Apr.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>26 Apr.</u> , 19 <u>55</u> , and that death occurred at <u>10</u> <u>A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Richard Allen</u> M.D. US Army Hosp AFG Md DATE SIGNED <u>26 Apr 55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Georgetown Center Md</u>	
24. REC'D BY REGISTRAR DATE <u>Apr 27 1955</u>		REGISTRAR'S SIGNATURE <u>Hellie P. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Lansing</u>		ADDRESS <u>Chelton Md</u>	

2145211270

CERTIFICATE OF DEATH

3740

Reg. Cert. No.

1. NAME OF DECEASED

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MEDICAL HISTORY

10. HISTORY OF PRESENT ILLNESS

11. MANNER OF DEATH

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF CLERK

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF DISTRICT CLERK

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF CITY CLERK

22. SIGNATURE OF TOWNSHIP CLERK

23. SIGNATURE OF VILLAGE CLERK

24. SIGNATURE OF POST OFFICE CLERK

25. SIGNATURE OF SCHOOL CLERK

26. SIGNATURE OF CHURCH CLERK

27. SIGNATURE OF SYNAGOGUE CLERK

28. SIGNATURE OF MOSQUE CLERK

29. SIGNATURE OF TEMPLE CLERK

30. SIGNATURE OF OTHER CLERK

31. SIGNATURE OF OTHER CLERK

32. SIGNATURE OF OTHER CLERK

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100. SIGNATURE OF OTHER CLERK

101. SIGNATURE OF OTHER CLERK

SMOKELESS

BUREAU V. S.

APR 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03727

3741

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford Jersey	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Aberdeen		28½ hours		TOWN RURAL Edgewood Hunterdon		67 X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
50 US Army Hospital Aberdeen Proving Ground Md				General Delivery R. F. D. 3 ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) DIANA		(Middle) KATHLEEN		(Last) STOB		(Month) (Day) (Year)	
						April 25 1955	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Female		White		Single		April 24 1955	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None		None		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Rudolph Charles Stobb				Sally Hope Bloomfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS (Father)			
No		None		Rudolph C Stobb Gen Dely Edgewood Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
776 X IMMEDIATE CAUSE (A) Prematurity						18½ hrs.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 24 APR 1955, to 25 APR 1955, that I last saw the deceased alive on 25 APR 1955, and that death occurred at 3:55 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
Richard Allen		M.D. US Army Hosp APG Md		25 APR 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4/27/55		Rock Cemetery		Army Chemical Center Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE Apr. 27 55		Nellie R. Perry		John S. Carrington Chesapeake Md			
2145212270							

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

NOTIFICATION

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health officer of the place of death.

BUREAU V. 8

APR 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3720

CERTIFICATE OF DEATH

03728

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Cecil</i>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
24 <i>Harve de Grace</i>		<i>10 years</i>		<i>Rising Sun</i>		<i>07X-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <i>Harford Memorial Hospital</i>							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Katie Sue Thomson</i>				<i>April 26 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Married</i>	<i>2-6-1882</i>	<i>73</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Domestic</i>				<i>Franklin County-Virginia</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>James P. Warren</i>				<i>Julia Fuller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Mr. J. A. Thomson, Rising Sun, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) <i>Uremia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>one wk.</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Diabetes</i>				<i>10 mps</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Arteriosclerosis - generalized</i>				<i>10 mps</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4/23</i> , 19 <i>55</i> , to <i>4/26</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/27</i> , 19 <i>55</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Orvil R. Taylor</i>				ADDRESS (Street, city, town, state) <i>Rising Sun, Md.</i>		DATE SIGNED <i>4/26/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4/30/55</i>		NAME OF CEMETERY OR CREMATORY <i>(family)</i>		LOCATION (City, town, or county) (State) <i>Sydnorsville, Va.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>Apr 28-55</i>		<i>G. L. Lewis M.D.</i>		<i>Ralph M. Reed, Rising Sun, Md.</i>			

CERTIFICATE OF DEATH

3750

REGISTRATION NUMBER OF DEATH

DECEASED

DATE OF DEATH

IN MEDICAL INVESTIGATION

STATE OF MARYLAND

BUREAU V. S.

MAY 2 1955

RECEIVED

NOTED

RECEIVED BY HEALTH DEPARTMENT OF MARYLAND
 MAY 2 1955
 BALTIMORE, MD

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3721

CERTIFICATE OF DEATH

03729

Reg. Dist. No. 185-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HARFORD</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>HARFORD</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
24 TOWN <u>Harford & Grace</u>		TOWN <u>Aberdeen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
71 <u>Harford Memorial Hosp.</u>		<u>Rt # 1</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Frances E.</u> (Middle) <u>Walker</u> (Last)		(Month) <u>April</u> (Day) <u>11</u> (Year) <u>1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>W</u>	<u>single</u>	<u>May 11 - 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
<u>Bookkeeper & clerk.</u>		<u>us Govt.</u>	<u>77</u> yrs.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>James T. Walker</u>		<u>Frances Raymond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>215-09-1561</u>	
17. INFORMANT & ADDRESS			
<u>Frances A. Clark - same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A)		<u>Cerebral Hemorrhage</u>	
ANTECEDENT CAUSE(S) DUE TO		<u>Cerebral Arteriosclerosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Arteriosclerotic Heart Disease</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>2-18-50</u> , 19 <u>50</u> , to <u>4-11-55</u> , that I last saw the deceased alive on <u>4-11-55</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Peter P. Rodman</u>		ADDRESS <u>Aberdeen Md</u>	
M.D.		DATE SIGNED <u>4-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/14/55</u>	<u>Grove Presbyterian cemetery</u>	<u>Aberdeen, Maryland</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE <u>Apr. 16 - 1955</u>	<u>G. L. Lewis m. d.</u>	<u>John E. Yarrington</u>	<u>Aberdeen Md.</u>

CERTIFICATE OF DEATH

3751

PLACE OF DEATH

NAME OF DECEASED
AGE
SEX
RACE
MARRIAGE

DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

BUREAU V. S.

APR 10 1955

RECEIVED